

		FOR OHF USE					

LL 1

**2001**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2001)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0041277</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>	
<b>Facility Name:</b> <u>Alden Northmoor Rehab &amp; HCC</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2001</u> to <u>12/31/2001</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
<b>Address:</b> <u>5831 N. Northwest Hwy</u> <u>Chicago</u> <u>60631</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
<b>County:</b> <u>Cook</u>		<b>Officer or Administrator of Provider</b> (Signed) _____ (Date) _____	
<b>Telephone Number:</b> <u>(773) 775-8080</u> <b>Fax #</b> <u>(773) 775-9672</u>		(Type or Print Name) <u>Steven M. Kroll</u>	
<b>IDPA ID Number:</b> <u>36-3847747</u>		(Title) <u>Chief Financial Officer</u>	
<b>Date of Initial License for Current Owners:</b> <u>03/29/96</u>		(Signed) _____ (Date) _____	
<b>Type of Ownership:</b>		<b>Paid Preparer</b> (Print Name and Title) _____	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____		(Firm Name & Address) _____ (Telephone) <u>( )</u> Fax # ( )	
<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____		<b>MAIL TO: OFFICE OF HEALTH FINANCE</b> <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b> <b>201 S. Grand Avenue East</b> <b>Springfield, IL 62763-0001</b> Phone # (217) 782-1630	
<b>GOVERNMENTAL</b> <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact: <b>Name:</b> <u>Steven M. Kroll</u> <b>Telephone Number:</b> <u>(773) 286-3883</u>			

## STATE OF ILLINOIS

Page 2

Facility Name & ID Number Alden Northmoor Rehab & HCC# 0041277 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>198</u>	Skilled (SNF)	<u>198</u>	<u>72,270</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>198</u>	TOTALS	<u>198</u>	<u>72,270</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>9,649</u>	<u>6,464</u>	<u>8,459</u>	<u>24,572</u>	8
9	SNF/PED					9
10	ICF	<u>32,502</u>	<u>8,010</u>		<u>40,512</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>42,151</u>	<u>14,474</u>	<u>8,459</u>	<u>65,084</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 90.06%

D. How many bed-hold days during this year were paid by Public Aid?

387 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)NONE

F. Does the facility maintain a daily midnight census?

YESG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 3/29/96

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 11/01/96 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter numberof beds certified 40 and days of care provided 8,346Medicare Intermediary ADMINISTAR FEDERAL, INC.

## IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/01 Fiscal Year: 12/31/01

\* All facilities other than governmental must report on the accrual basis.

## STATE OF ILLINOIS

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Facility Name &amp; ID Number

Alden Northmoor Rehab &amp; HCC

# 0041277

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

## V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	414,837	40,917		455,754	677	456,431		456,431			1
2	Food Purchase		367,456		367,456	(32,452)	335,004	(352)	334,652			2
3	Housekeeping	187,128	42,834		229,962	1,603	231,565		231,565			3
4	Laundry	73,900	5,829		79,729	180	79,909		79,909			4
5	Heat and Other Utilities			283,679	283,679		283,679		283,679			5
6	Maintenance	47,084		192,447	239,531	911	240,442	3,735	244,177			6
7	Other (specify):*											7
8	<b>TOTAL General Services</b>	722,949	457,036	476,126	1,656,111	(29,081)	1,627,030	3,383	1,630,413			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			20,400	20,400		20,400		20,400			9
10	Nursing and Medical Records	2,649,027	98,592	4,752	2,752,371	5,665	2,758,036	(8,744)	2,749,292			10
10a	Therapy	22,526			22,526		22,526		22,526			10a
11	Activities	62,419	4,792	1,838	69,049	128	69,177		69,177			11
12	Social Services	47,357		840	48,197		48,197		48,197			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	2,781,329	103,384	27,830	2,912,543	5,793	2,918,336	(8,744)	2,909,592			16
	<b>C. General Administration</b>											
17	Administrative	159,592			159,592		159,592		159,592			17
18	Directors Fees											18
19	Professional Services			1,012,580	1,012,580	(29,236)	983,344	(886,570)	96,774			19
20	Dues, Fees, Subscriptions & Promotions			29,539	29,539		29,539	(15,230)	14,309			20
21	Clerical & General Office Expenses	527,016	15,860	60,841	603,717	42	603,759	64,098	667,857			21
22	Employee Benefits & Payroll Taxes			513,602	513,602	23,246	536,848	70,804	607,652			22
23	Inservice Training & Education			2,400	2,400		2,400		2,400			23
24	Travel and Seminar			3,224	3,224		3,224	14,378	17,602			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			102,501	102,501		102,501	1,243	103,744			26
27	Other (specify):*			217,935	217,935		217,935	(217,935)				27
28	<b>TOTAL General Administration</b>	686,608	15,860	1,942,622	2,645,090	(5,948)	2,639,142	(969,212)	1,669,930			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	4,190,886	576,280	2,446,578	7,213,744	(29,236)	7,184,508	(974,573)	6,209,935			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## STATE OF ILLINOIS

Page 4

Facility Name &amp; ID Number Alden Northmoor Rehab &amp; HCC

#0041277

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			37,791	37,791		37,791	300,576	338,367			30
31	Amortization of Pre-Op. & Org.							10,046	10,046			31
32	Interest			326,615	326,615		326,615	430,671	757,286			32
33	Real Estate Taxes					29,236	29,236	384,753	413,989			33
34	Rent-Facility & Grounds			1,432,862	1,432,862		1,432,862	(1,432,130)	732			34
35	Rent-Equipment & Vehicles			9,417	9,417		9,417	27,304	36,721			35
36	Other (specify):*							53,550	53,550			36
37	<b>TOTAL Ownership</b>			1,806,685	1,806,685	29,236	1,835,921	(225,230)	1,610,691			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		484,749	1,161,050	1,645,799		1,645,799	(800,383)	845,416			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			108,405	108,405		108,405		108,405			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		484,749	1,269,455	1,754,204		1,754,204	(800,383)	953,821			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,190,886	1,061,029	5,522,718	10,774,633		10,774,633	(2,000,186)	8,774,447			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name &amp; ID Number Alden Northmoor Rehab &amp; HCC

# 0041277

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

## VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(8,940)	30		9
10	Interest and Other Investment Income	(78,940)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,137)	2		13
14	Non-Care Related Interest	(231,972)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(15,703)	32		18
19	Entertainment				19
20	Contributions	(2,674)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(217,935)	27		24
25	Fund Raising, Advertising and Promotional	(9,194)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(2,998)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (570,493)		\$	30

OHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(1,008,822)	pg 6's	34
35	Other- Attach Schedule	(420,871)	pg 5a	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,429,693)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B) )	\$ (2,000,186)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Alden Northmoor Rehab & HCC

ID# 0041277

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	non-allowable marketing fee (gl 5708)	\$ (1,164)	6	1
2	PAC FEES - IHCA	(713)	20	2
3	UTILITY - LATE FEES	(10,996)	6	3
4	TELEPHONE - LATE FEE	(199)	21	4
5	NON COSST PART B THERAPY C/A 5212-14	(49,701)	39	5
6	NON COST HMO NS C/A #5026	(17,397)	39	6
7	NON COST HMO DRUG C/A #5042	(28,993)	39	7
8	NON COST HMO OXYGEN C/A #5080	(2,636)	39	8
9	NON COST HMO THERAPY #5040	(294,961)	39	9
10	NON COST HMO ISOLATION C/A #5093	(920)	39	10
11	INTEREST INCOME FROM FACILITY	(6,218)	32	11
12	AGREE DEF MAINT EXP TO PAGE 21	4,284	6	12
13	back out related party interest expense	(5,515)	32	13
14	back over-recorded interest (audit adj) insur exp	(5,742)	26	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(420,871)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Alden Northmoor Rehab &amp; HCC

# 0041277

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,137)	0	0	1,785	0	0	0	0	0	0	0	(352)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(7,876)	0	11,649	0	0	0	(38)	0	0	0	0	3,735	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(10,013)</b>	<b>0</b>	<b>11,649</b>	<b>1,785</b>	<b>0</b>	<b>0</b>	<b>(38)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>3,383</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	(7,951)	(793)	0	0	0	0	0	0	(8,744)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(7,951)</b>	<b>(793)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(8,744)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	3,200	(889,770)	0	0	0	0	0	0	0	0	(886,570)	19
20	Fees, Subscriptions & Promotions	(15,579)	0	349	0	0	0	0	0	0	0	0	(15,230)	20
21	Clerical & General Office Expenses	(199)	481	33,721	19,328	10,767	0	0	0	0	0	0	64,098	21
22	Employee Benefits & Payroll Taxes	0	0	68,597	0	2,207	0	0	0	0	0	0	70,804	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	14,378	0	0	0	0	0	0	0	0	14,378	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(5,742)	6,985	0	0	0	0	0	0	0	0	0	1,243	26
27	Other (specify):*	(217,935)	0	0	0	0	0	0	0	0	0	0	(217,935)	27
28	<b>TOTAL General Administration</b>	<b>(239,455)</b>	<b>10,666</b>	<b>(772,725)</b>	<b>19,328</b>	<b>12,974</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(969,212)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(249,468)</b>	<b>10,666</b>	<b>(761,076)</b>	<b>13,162</b>	<b>12,181</b>	<b>0</b>	<b>(38)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(974,573)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name &amp; ID Number Alden Northmoor Rehab &amp; HCC

# 0041277

Report Period Beginning:

01/01/2001 Ending:

12/31/2001

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	<b>D. Ownership</b>												
30	Depreciation	(8,940)	294,960	11,855	0	2,701	0	0	0	0	0	0	300,576 30
31	Amortization of Pre-Op. & Org.	0	3,060	271	0	0	6,715	0	0	0	0	0	10,046 31
32	Interest	(338,348)	710,444	42,376	0	4,123	12,076	0	0	0	0	0	430,671 32
33	Real Estate Taxes	0	376,413	7,637	0	703	0	0	0	0	0	0	384,753 33
34	Rent-Facility & Grounds	0	(1,432,862)	732	0	0	0	0	0	0	0	0	(1,432,130) 34
35	Rent-Equipment & Vehicles	0	0	27,304	0	0	0	0	0	0	0	0	27,304 35
36	Other (specify):*	0	53,550	0	0	0	0	0	0	0	0	0	53,550 36
37	<b>TOTAL Ownership</b>	<b>(347,288)</b>	<b>5,565</b>	<b>90,175</b>	<b>0</b>	<b>7,527</b>	<b>18,791</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(225,230) 37</b>
	<b>Ancillary Expense</b>												
	<b>E. Special Cost Centers</b>												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	(394,608)	0	0	(39,016)	(83,127)	(283,632)	0	0	0	0	0	(800,383) 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	<b>TOTAL Special Cost Centers</b>	<b>(394,608)</b>	<b>0</b>	<b>0</b>	<b>(39,016)</b>	<b>(83,127)</b>	<b>(283,632)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(800,383) 44</b>
	<b>GRAND TOTAL COST</b>												
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(991,364)</b>	<b>16,231</b>	<b>(670,901)</b>	<b>(25,854)</b>	<b>(63,419)</b>	<b>(264,841)</b>	<b>(38)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(2,000,186) 45</b>

Facility Name &amp; ID Number Alden Northmoor Rehab &amp; HCC

# 0041277

Report Period Beginning: 01/01/2001 Ending: 12/31/2001

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ALDEN MANAGEMENT SERVICES, INC.	100	See page 6K		See page 6K		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	34 Rental Income	\$ 1,432,862	Alden Northmoor Associates Limited Partnership		\$	\$ (1,432,862)
2	V	32 Interest Income	78,940	Alden Northmoor Associates Limited Partnership			(78,940)
3	V	32 Interest - RR	5,515	Alden Northmoor Associates Limited Partnership			(5,515)
4	V	19 Audit Expense		Alden Northmoor Associates Limited Partnership		3,200	3,200
5	V	21 Misc		Alden Northmoor Associates Limited Partnership		481	481
6	V	33 Real estate taxes		Alden Northmoor Associates Limited Partnership		376,413	376,413
7	V	26 Insurance		Alden Northmoor Associates Limited Partnership		6,985	6,985
8	V	32 Interest - Mortgage		Alden Northmoor Associates Limited Partnership		654,347	654,347
9	V	32 Interest - loan		Alden Northmoor Associates Limited Partnership		135,037	135,037
10	V	36 Mortgage ins. Prem.		Alden Northmoor Associates Limited Partnership		53,550	53,550
11	V	32 Interest		Alden Northmoor Associates Limited Partnership		5,515	5,515
12	V	30 Depreciation		Alden Northmoor Associates Limited Partnership		294,960	294,960
13	V	31 Amortization		Alden Northmoor Associates Limited Partnership		3,060	3,060
14	Total		\$ 1,517,317			\$ 1,533,548	\$ * 16,231

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name &amp; ID Number Alden Northmoor Rehab &amp; HCC

# 0041277

Report Period Beginning: 01/01/2001 Ending: 12/31/2001

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	22 Employee Benefits	\$	Alden Management Services, Inc.	100.00%	\$ 68,597	\$ 68,597	15
16	V	19 Management fees	902,440	Alden Management Services, Inc.		12,670	(889,770)	16
17	V	21 Gen'l & Admin.		Alden Management Services, Inc.		33,721	33,721	17
18	V	6 maintenance/utilities		Alden Management Services, Inc.		11,649	11,649	18
19	V	24 autos/seminars		Alden Management Services, Inc.		14,378	14,378	19
20	V	20 dues/subscriptions		Alden Management Services, Inc.		349	349	20
21	V	30 depreciation		Alden Management Services, Inc.		11,855	11,855	21
22	V	31 amortization		Alden Management Services, Inc.		271	271	22
23	V	33 real estate tax		Alden Management Services, Inc.		7,637	7,637	23
24	V	34 rent		Alden Management Services, Inc.		732	732	24
25	V	35 rent-equip/vehicles		Alden Management Services, Inc.		27,304	27,304	25
26	V	32 interest		Alden Management Services, Inc.		42,376	42,376	26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 902,440			\$ 231,539	\$ * (670,901)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name &amp; ID Number Alden Northmoor Rehab &amp; HCC

# 0041277

Report Period Beginning: 01/01/2001 Ending: 12/31/2001

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	TUBE FEEDING	\$ 9,316	PYRAMID HEALTH CARE SERVICES	100.00%	\$ 11,101	\$ 1,785	15
16	V	10	NURSING SUPPLIES	14,147	PYRAMID HEALTH CARE SERVICES		6,196	(7,951)	16
17	V	39	SUPPLIES / PER DIEM FEES	95,160	PYRAMID HEALTH CARE SERVICES		56,144	(39,016)	17
18	V	21	GENERAL & ADMIN.		PYRAMID HEALTH CARE SERVICES		19,328	19,328	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 118,623			\$ 92,769	\$ * (25,854)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name &amp; ID Number Alden Northmoor Rehab &amp; HCC

# 0041277

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39 DRUGS	\$ 283,269	FORUM EXTENDED CARE II	100.00%	\$ 221,962	\$ (61,307)	15
16	V	10 HOUSE STOCK	3,665	FORUM EXTENDED CARE II		2,872	(793)	16
17	V	39 IV	100,819	FORUM EXTENDED CARE II		78,999	(21,820)	17
18	V	22 EMPLOYEE BENEFITS		FORUM EXTENDED CARE II		2,207	2,207	18
19	V	21 GENERAL & ADMIN		FORUM EXTENDED CARE II		10,767	10,767	19
20	V	32 INTEREST		FORUM EXTENDED CARE II		4,123	4,123	20
21	V	33 REAL ESTATE TAXES		FORUM EXTENDED CARE II		703	703	21
22	V	30 DEPRECIATION		FORUM EXTENDED CARE II		2,701	2,701	22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 387,753			\$ 324,334	\$ * (63,419)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name &amp; ID Number Alden Northmoor Rehab &amp; HCC

# 0041277

Report Period Beginning: 01/01/2001 Ending: 12/31/2001

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39 CPT REVENUES	\$ 762,809	COMMUNITY PHYSICAL THERAPY	100.00%	\$ 479,177	\$ (283,632)	15
16	V	31 AMORTIZATION				6,715	6,715	16
17	V	32 INTEREST				12,076	12,076	17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 762,809			\$ 497,968	\$ * (264,841)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name &amp; ID Number Alden Northmoor Rehab &amp; HCC

# 0041277

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	6 maintenance	\$ 6,102	Alden Bennett Construction	100.00%	\$ 6,064	\$ (38)	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 6,102			\$ 6,064	\$ *	(38) 39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

## STATE OF ILLINOIS

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Facility Name & ID Number Alden Northmoor Rehab & HCC # 0041277 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Floyd Schlossberg a.	President	CEO	100.00	334,773	2.57	6.44	salary	\$ 23,051	21-1	1
2	Lauren Magnusson b.	Nurse Coordinator	Nursing Admin.		74,949	2.57	6.44	salary	5,161	21-1	2
3	Terry Magnusson c.	Maint. Supervisor	Construct/maint		68,470	2.57	6.44	salary	4,714	21-1	3
4											4
5											5
6	a. President and sole stockholder of Alden Management Services, Inc.										6
7	b. Daughter of Floyd Schlossberg. Lauren is a nurse coordinator.										7
8	c. Son-in-law of Floyd Schlossberg. Terry is in maintenance and construction.										8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 32,926		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Alden Northmoor Rehab & HCC # 0041277 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Alden Management Services, Inc.  
 Street Address 4200 W. Peterson Ave.  
 City / State / Zip Code Chicago, IL 60646  
 Phone Number (773)286-3883  
 Fax Number (773)286-3743

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	<a href="#">See attached schedule</a>				\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	WMF/PRUDENTIAL		X	MORTGAGE	\$72,788.73	7/1/96	\$ 9,194,900	\$ 9,062,287	12/1/35	9.5000	\$ 654,347	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	RELATED PARTY - CPT	X		OPERATIONS	NONE					VARIES	12,076	6	
7	RELATED PARTY - AMS	X		OPERATIONS	NONE					VARIES	42,376	7	
8	IOD LOAN-WMF/PRUDENT		X	OPERATIONS	\$12,958.00	12/1/99	1,941,500	1,914,525		VARIES	135,037	8	
9	TOTAL Facility Related				\$85,746.73		\$ 11,136,400	\$ 10,976,812			\$ 843,836	9	
	B. Non-Facility Related*												
10	NM ASSOC. INTERET INCOME										(84,455)	10	
11	RELATED PARTY - FECII	X		OPERATIONS	NONE					VARIES	4,123	11	
12	INTEREST INCOME										(6,218)	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (86,550)	14	
15	TOTALS (line 9+line14)						\$ 11,136,400	\$ 10,976,812			\$ 757,286	15	

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

Facility Name &amp; ID Number Alden Northmoor Rehab &amp; HCC

# 0041277 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

## B. Real Estate Taxes

		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2000 report.		\$	457,000	1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	410,413	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	(46,587)	3	
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	423,000	4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	29,236	5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	405,649	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	1996	359,526	8		
	1997	429,651	9		
	1998	437,278	10		
	1999	437,918	11		
	2000	410,413	12		
<b>RELATED PARTY - FECH 703</b>					
<b>RELATED PARTY - AMS 7637</b>					
<b>FACILITY TAXES 379913</b>					
<b>TOTAL OF LINE 33 388253</b>					
				<b>FOR OHF USE ONLY</b>	
				13	FROM R. E. TAX STATEMENT FOR 2000 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

## NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

FACILITY NAME Alden Northmoor Rehab & HCC COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0041277

CONTACT PERSON REGARDING THIS REPORT STEVEN M. KROLL

TELEPHONE 773-286-3883 FAX #: ( )

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

### B. Real Estate Tax Cost Allocations

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

## Page 10A

A.
Square Feet:
83,872

B. General Construction Type:

Exterior
BRICK

Frame
STEEL

Number of Stories
4

C.
Does the Operating Entity?

☐ (a) Own the Facility
☒ (b) Rent from a Related Organization.
☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D.
Does the Operating Entity?

☐ (a) Own the Equipment
☒ (b) Rent equipment from a Related Organization.
☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E.
List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F.
Does this cost report reflect any organization or pre-operating costs which are being amortized?

☒ YES
☐ NO

If so, please complete the following:

1. Total Amount Incurred:
29,847

2. Number of Years Over Which it is Being Amortized:
5

3. Current Period Amortization:
3,060

4. Dates Incurred:
1994-1999

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	NURSING HOME	53,009		\$ 1,429,683	1
2					2
3	TOTALS	53,009		\$ 1,429,683	3

Facility Name &amp; ID Number Alden Northmoor Rehab &amp; HCC

# 0041277

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

**XL OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	198			1994	\$ 8,796,651	\$ 228,856	40	\$ 219,916	\$ (8,940)	\$ 1,302,146	4
5											5
6	related party-Forum			1978	18,359		22			18,359	6
7											7
8											8
	<b>Improvement Type**</b>										
9	Cable installation			1996	5,704	665	5	665		5,704	9
10	Cable installation			1996	3,286	548	5	548		3,286	10
11	Fire alarm			1996	17,753	1,183	15	1,183		6,213	11
12	Install additional outlet			1997	2,108	210	10	210		1,036	12
13	Install additional outlet			1997	1,116	112	10	112		549	13
14	Install additional outlet			1997	2,668	267	10	267		1,334	14
15	Access control materials			1997	4,714	471	10	471		2,003	15
16	HVAC repair			1997	6,413	1,283	5	1,283		5,665	16
17	Phone line installation			1997	2,768	554	5	554		2,445	17
18	Phone line installation			1997	3,096	619	5	619		2,528	18
19	Equipment for security system			1998	4,170	417	10	417		1,668	19
20	Change belt on fans & airhandlers			1998	2,012	402	5	402		1,509	20
21	Wire third floor & twenty bed jacks			1998	7,189	719	10	719		2,695	21
22	Repair pump motor on elevator			1998	3,500	175	20	175		612	22
23	Install pump motor on dishwasher			1998	2,029	203	10	203		727	23
24	Install door locks			1998	8,157	816	10	816		3,127	24
25	Door system work			1998	775	77	10	77		245	25
26	Repair nurse call system			1998	275	27	10	27		87	26
27	Repair nurse call system			1998	1,032	103	10	103		326	27
28	Repair nurse call system			1998	982	98	10	98		311	28
29	Chiller			1998	52,667	3,511	15	3,511		10,826	29
30	Computer & training & installation			1998	3,158	632	5	632		2,474	30
31	Canopy construction			1998	73,120	4,875	15	4,875		18,280	31
32	Continue on page 12A										32
33											33
34											34
35											35
36											36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Climate Service - replace compressor	1999	\$ 2,603	\$ 173	15	\$ 173		\$ 521		37
38	Washtown equipment - dryer installation	1999	2,875	288	10	288		791		38
39	Climate Service - repair chiller pump	1999	2,940	588	5	588		1,470		39
40	Equipment INT - dryer repair	1999	130	26	5	26		65		40
41	Rykoff Sexton - coffee machine	1999	2,021	404	5	404		976		41
42	Equipment INT - dryer repair	1999	1,891	378	5	378		882		42
43	Climate Service - chiller maint	1999	3,071	614	5	614		1,382		43
44	United Communication group-phone repair	1999	1,593	159	10	159		345		44
45	Long elevator	1999	2,168	108	20	108		235		45
46	Climate service - ice machine repair	1999	1,885	189	10	189		393		46
47	Climate service - condensor repair	1999	3,579	239	15	239		556		47
48	ABC -misc. Work	2000	16,003	1,600	10	1,600		1,734		48
49	CSI-change exhausst belt - hvac	2000	1,695	339	5	339		678		49
50	ABC - metla frame/heating vent	2000	2,048	102	20	102		188		50
51	ABC - misc. const. Work	2000	2,059	412	5	412		480		51
52	GT mechanical - gas line	2001	1,563	169	10	169		169		52
53	Coker services-repair washer	2001	2,013	168	10	168		168		53
54	Coker services -install gas unit	2001	4,125	344	10	344		344		54
55	DBS contracting -lawn sprinkler	2001	2,215	221	15	221		221		55
56	DBS contracting -lawn sprinkler	2001	2,575	200	15	200		200		56
57	GT mechanical -condensor fan motors	2001	1,867	83	15	83		83		57
58	CSI Coker - service on cleveland MD2224CGA1	2001	1,582	26	10	26		26		58
59										59
60										60
61										61
62										62
63										63
64										64
65										65
66										66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 9,086,203	\$ 253,653		\$ 244,713	\$ (8,940)	\$ 1,406,062		70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 9,086,203	\$ 253,653		\$ 244,713	\$ (8,940)	\$ 1,406,062	1
2	Related Party-Forum:								2
3	Leasehold Improvement-Remodeling	1980	19,335		20			19,335	3
4	Leasehold Improvement-Remodeling	1980	1,208		10			1,208	4
5	Leasehold Improvement-Remodeling	1986	645		5			645	5
6	Leasehold Improvement-Remodeling	1990	404		5			404	6
7	Leasehold Improvement-Remodeling	1991	94		5			94	7
8	Leasehold Improvement-Remodeling	1993	8,304	830	10	830		7,474	8
9	Leasehold Improvement-Remodeling	1993	6,504	671	9.7	671		6,035	9
10	Leasehold Improvement-sign	1994	261	22	12	22		174	10
11	Leasehold Improvement-dryvit	1995	443	44	10	44		310	11
12	Leasehold Improvement-new ac	1999	723	48	15	48		145	12
13	Leasehold Improvement-roof	1985	972	51	19	51		870	13
14	Leasehold Improvement-roof	1994	863	58	15	58		460	14
15	Leasehold Improvement-roof	1997	819	55	15	55		273	15
16	Leasehold Improvement-roof	1998	1,390	93	15	93		371	16
17	Leasehold Improvement-parking lot asphalt	2000	111	11	10	11		22	17
18	Leasehold Improvement-hallway lighting	2001	155	16	10	16		16	18
19	Leasehold Improvement-DAI	2001	195	19	10	19		19	19
20									20
21	Related Party-AMS:								21
22	Leasehold Improvement-Remodeling	1993	4,266		7			4,266	22
23	Leasehold Improvement-Remodeling	1994	2,112	64	7	64		2,112	23
24									24
25	related party-Forum Ext. Care II		11,030	585	10	585		846	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,146,037	\$ 256,220		\$ 247,280	\$ (8,940)	\$ 1,451,141	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,156,517	\$ 84,953	\$ 84,953	\$	various	\$ 458,504	71
72	Current Year Purchases	28,006	1,669	1,669		various	1,669	72
73	Fully Depreciated Assets	32,868	668	668		various	32,868	73
74								74
75	TOTALS	\$ 1,217,391	\$ 87,290	\$ 87,290	\$		\$ 493,041	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	various	van/bus	1998-2000	\$ 11,938	\$ 3,797	\$ 3,797	\$	3	\$ 6,200	76
77										77
78										78
79										79
80	TOTALS			\$ 11,938	\$ 3,797	\$ 3,797	\$		\$ 6,200	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 11,805,049	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 347,306	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 338,367	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (8,940)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,950,382	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: NORTHMOOR ASSOCIATES - RELATED PARTY

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☒ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☒ NO Terms: \_\_\_\_\_ \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ 9,417 Description: COPY MACHINE

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	RELATED PARTY		\$	\$	17
18	SEE PAGE 8a		2275	27,304	18
19					19
20					20
21	TOTAL		\$	\$ 27,304	21

10. Effective dates of current rental agreement:

Beginning 4/1/1996

Ending 3/31/2006

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. 12/31/2002 \$ 1564K

13. 12/31/2003 \$ 1564K

14. 12/31/2004 \$ 1564K

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</p> <p> <input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO                 </p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ \_\_\_\_\_

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
 (c) For in-house training programs only. Do not include fringe benefits.  
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

**XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)**

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 263,656
2	Licensed Speech and Language Development Therapist	39-3	hrs			96,901				96,901	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39-3	hrs			355,337				355,337	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	SEE PAGE 16A	# of prescrpts				175,085			175,085	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):	SEE PAGE 16A					(45,563)			(45,563)	13
14	TOTAL			\$		\$ 715,894	\$ 129,522		\$	845,416	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 85,848	\$ 426,578	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 300,000 )	2,025,172	2,025,172	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance		8,900	6
7	Other Prepaid Expenses	105,534	136,409	7
8	Accounts Receivable (owners or related parties)	2,152,950	3,603,472	8
9	Other(specify): <u>ESCROWS</u>	372,960	929,757	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 4,742,464	\$ 7,130,288	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,429,683	13
14	Buildings, at Historical Cost		9,095,841	14
15	Leasehold Improvements, at Historical Cost	302,720	1,318,168	15
16	Equipment, at Historical Cost	126,466	126,466	16
17	Accumulated Depreciation (book methods)	(162,829)	(1,860,000)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		122,412	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(9,041)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 266,357	\$ 10,223,529	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 5,008,821	\$ 17,353,817	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 2,323,118	\$ 2,696,432	26
27	Officer's Accounts Payable		69,926	27
28	Accounts Payable-Patient Deposits	94,156	94,156	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	258,040	258,040	30
31	Accrued Taxes Payable (excluding real estate taxes)	69,554	69,554	31
32	Accrued Real Estate Taxes(Sch.IX-B)		423,000	32
33	Accrued Interest Payable		65,621	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	(808,502)	(808,502)	35
	<b>Other Current Liabilities(specify):</b>			
36	<u>DUE IDPA</u>	302,833	302,833	36
37	<u>DUE TO AFFILIATES</u>	331,505	408,863	37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 2,570,704	\$ 3,579,923	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable		1,914,525	39
40	Mortgage Payable		9,062,287	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>DUE TO BANKS &amp; OTHERS</u>	1,117,045	1,117,045	43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 1,117,045	\$ 12,093,857	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 3,687,749	\$ 15,673,780	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 1,321,072	\$ 1,680,037	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 5,008,821	\$ 17,353,817	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,039,805	1
2	Restatements (describe):		2
3	EXTERNAL AUDITOR ADJUSTMENT MADE AFTER 2000		3
4	COST REPORT WAS FILED. THE ADJUSTMENT HAD NO	(498,543)	4
5	EFFECT ON REIMBURSABLE COSTS		5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 541,262	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	779,810	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 779,810	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,321,072	24 *

\* This must agree with page 17, line 47.

**VII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 10,612,846	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 10,612,846	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	135,210	6
7	Oxygen	26,123	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 161,333	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,423	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	3,758	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	258,218	21
22	Laundry	765	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 264,164	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	6,218	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 6,218	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>MISC. REVENUE</b>	3,881	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 3,881	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 11,048,442	30

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,656,111	31
32	Health Care	2,898,504	32
33	General Administration	2,645,090	33
	<b>B. Capital Expense</b>		
34	Ownership	1,806,685	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	1,659,838	35
36	Provider Participation Fee	108,405	36
	<b>D. Other Expenses (specify):</b>		
37	RELATED PARTY SALARIES INCLUDED IN COL A	(10,623)	37
38	RELATED PARTY SALARIES INCLUDED IN COL A	(7,516)	38
39	RELATED PARTY SALARIES INCLUDED IN COL A	(487,862)	39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 10,268,632	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	779,810	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 779,810	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? \_\_\_\_\_ If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name &amp; ID Number Alden Northmoor Rehab &amp; HCC

# 0041277

Report Period Beginning: 01/01/2001

Ending:

12/31/2001

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,401	2,528	\$ 61,179	\$ 24.20	1
2	Assistant Director of Nursing	2,247	2,445	61,975	25.35	2
3	Registered Nurses	39,640	42,358	1,030,484	24.33	3
4	Licensed Practical Nurses	10,427	11,123	219,106	19.70	4
5	Nurse Aides & Orderlies	104,396	108,759	1,196,051	11.00	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,801	1,933	22,618	11.70	8
9	Activity Director	1,946	1,994	18,696	9.38	9
10	Activity Assistants	3,986	4,204	43,724	10.40	10
11	Social Service Workers	1,941	2,085	34,372	16.49	11
12	Dietician					12
13	Food Service Supervisor	1,402	1,522	21,681	14.25	13
14	Head Cook					14
15	Cook Helpers/Assistants	34,022	36,044	393,366	10.91	15
16	Dishwashers					16
17	Maintenance Workers	1,698	1,786	35,051	19.63	17
18	Housekeepers	20,927	22,424	187,127	8.34	18
19	Laundry	7,410	7,957	73,899	9.29	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	592	600	12,985	21.64	23
24	Clerical	6,836	7,380	115,139	15.60	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,785	2,096	62,700	29.91	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,417	1,417	17,232	12.16	31
32	Other Health C: Clinical Support	1,650	1,837	38,620	21.02	32
33	Other(specify) Personnel	1,941	2,006	38,880	19.38	33
34	TOTAL (lines 1 - 33)	248,465	262,498	\$ 3,684,885 *	\$ 14.04	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	monthly	20,400	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	4,752	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	38	1,838	11-3	44
45	Social Service Consultant	17	840	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	55	\$ 27,830		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name &amp; ID Number Alden Northmoor Rehab &amp; HCC

# 0041277

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

## XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Agpasa(4871)/Dalicandro(4349)	administrative	0	\$ 9,220	Workers' Compensation Insurance	\$ 58,589	IDPH License Fee	\$	
executives-various	management	0	74,683	Unemployment Compensation Insurance	25,760	Advertising: Employee Recruitment	466	
Barman	administrative	0	19,354	FICA Taxes	281,544	Health Care Worker Background Check	1,120	
Dipaolo(8853)/Glantz(1473)	administrative	0	10,326	Employee Health Insurance	28,126	(Indicate # of checks performed _____)		
Palazzo(4803)/Weber(4292)	administrative	0	9,095	Employee Meals	32,452	FOX VALLEY FIRE	2,583	
Umadhay	administrative	0	36,914	Illinois Municipal Retirement Fund (IMRF)*		CITY OF CHICAGO	1,553	
	administrative	0		CHICAGO HEAD TAX	6,152	IHCA	8,398	
TOTAL (agree to Schedule V, line 17, col. 1)				UNION HEALTH AND WELFARE	74,908	MISC. FEES	(160)	
(List each licensed administrator separately.)			\$ 159,592	PENSION	25,800			
B. Administrative - Other				EMPLOYEE VACC.	1,066	related party-ams	349	
Description			Amount	EMPLOYEE RELATIONS	345	Less: Public Relations Expense	( )	
			\$	MISC. PAYROLL COSTS	2,106	Non-allowable advertising	( )	
				related party-ams/FECH	70,804	Yellow page advertising	( )	
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 607,652	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 14,309	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
(Attach a copy of any management service agreement)				Description	Line #	Amount	Description	Amount
C. Professional Services							Out-of-State Travel	\$
Vendor/Payee	Type	Amount						
ALDEN MANAGEMENT	MANAGEMENT FEES	\$ 902,440					In-State Travel	2,499
BLACKMAN KALLICK	ACCOUNTING	14,000						
LEGAL FEES SEE PAGE 21a		37,983						
US Energy	CONSULTING	1,919					Seminar Expense	725
JCAH	ACCREDITATION	8,036						
URBAN RE TAX APPR.	APPRAISAL	3,500					related party-ams	14,378
MAYER, BROWN	LEGAL	22,735					Entertainment Expense	( )
SCHMIDT & SALZMAN	LEGAL	7,670					(agree to Sch. V, line 24, col. 8)	
FIRST REAL ESTATE	CONSULTING	3,000					TOTAL	\$ 17,602
AMS	CONSULTING	3,748						
SYSTEMATIC MGMT CARE	CONSULTING	7,500						
MISC. COSTS	CONSULTING	49						
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL	\$			
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 1,012,580					

\* Attach copy of IMRF notifications

\*\*See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
 (See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	INSTALL BELTS ON A/C	5/97	\$ 2,367	3	\$ 789	\$ 789	\$ 263	\$	\$	\$	\$	\$	\$
2	REPAIR AIR COMPRES	10/97	3,174	3	1,058	1,058	794						
3	REPAIR MOTOR, VENT	11/97	3,140	3	1,047	1,047	872						
4	HVAC REPAIR	6/98	2,661	3	517	887	887	370					
5	INSTALLL CONTRLS	7/98	3,900	3	650	1,300	1,300	650					
6	INSTL PHASE MONITO	7/98	4,250	3	708	1,417	1,417	708					
7	REPLACE COOLING FA	12/98	1,219	3	34	406	406	372					
8	REPAIR FAN FREQUE	12/98	446	3	12	149	149	136					
9	CLIMATE SER. ADJ '98	12/98	(446)	3		(161)	(149)	(136)					
10	PAINTING >1500 '99	7/99	6,870	3		1,145	2,290	2,290	1,145				
11	ABC- MISC. JOBS	7/00	3,677	3			613	1,226	1,226	612			
12	ABC- REPAIR CARPET	9/00	2,042	3			227	681	681	453			
13	ABC - MISC. JOBS	11/00	5,101	3			283	1,700	1,700	1,418			
14	PAINTING >1500 '00	7/00	5,943	3			990	1,981	1,981	990			
15													
16													
17													
18													
19													
20	TOTALS		\$ 44,344		\$ 4,815	\$ 8,037	\$ 10,342	\$ 9,978	\$ 6,733	\$ 3,473	\$	\$	\$

## XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. 8398
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 23,322 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 108,405  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 32,452 Has any meal income been offset against related costs? NO Indicate the amount. \$ N/A
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? N/A  
d. Have vehicle usage logs been maintained? YES  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
g. Does the facility transport residents to and from day training? NO  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? YES  
Firm Name: BDO SEIDMAN The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? NO If no, please explain. NOT YET COMPLETED
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES  
Attach invoices and a summary of services for all architect and appraisal fees.